(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 01 B. WING HAL051002 02/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **474 JERRY ROAD AUTUMN HOME CARE OF JOHNSTON COUNT SELMA, NC 27576** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) C 000 Initial Comments C 000 This is a Report of a Biennial Construction Survey conducted by Greg Cates and Billy Bryant on February 12, 2016. Based on information gathered from our files, the Facility was first licensed or submitted for licensure on or about August 1, 1984 for Twelve (12) Beds. Based on the above information, the facility is required to meet the 1984 Minimum Standards and Regulations for Homes for the Aged; the applicable portions of the 2005 North Carolina Rules for Adult Care Homes of Seven or More Beds; and the 1978 North Carolina State Building Code, Revision 10. C 101 C 101 Existing Licensed Fac- No less than '71 Rules SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0301 APPLICATION OF PHYSICAL PLANT REQUIREMENTS The physical plant requirements for each adult care home shall be applied as follows: (2) Except where otherwise specified, existing licensed facilities or portions of existing licensed facilities shall meet licensure and code requirements in effect at the time of construction, change in service or bed count, addition, renovation, or alteration; however in no case shall the requirements for any licensed facility where no addition or renovation has been made, be less than those requirements found in the 1971 "Minimum and Desired Standards and Regulations" for "Homes for the Aged and Infirm", copies of which are available at the Division of Health Service Regulation at no cost; This Rule is not met as evidenced by: 1- Based on observations, the facility has failed to

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED		
HAL051002		B. WING		02/4	02/12/2016		
		HALU51002				02/1	12/2016
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
AUTUMN HOME CARE OF JOHNSTON COUNT 474 JERRY SELMA, NO							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETE DATE
C 101	Continued From pa	ge 1		C 101			
	A finish rating. This	ls of the corridor have deficiency may affect that the facility defined and the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the facility is a second control of the facility that the faci	ct all				
	Findings include	e:					
	a- The corridor	has a plywood wain	scoting.				
C 164	Housekeeping and	Furnishings-Clean,	Repaired	C 164			
	FURNISHINGS (a) Adult care home (1) have walls, ceil coverings kept clea (2) have no chronic (3) have furniture of	06 HOUSEKEEPI es shall: ings, and floors or fl n and in good repair	oor ; oair;				
		et as evidenced by: vations, the facility hand g and furnishings clo					
	Findings include	e:					
	a- The carpet ir to be stained.	า the Living Room a _เ	opears				
C 166	Housekeeping-Mair	ntained Free of Haza	ards	C 166			
	FURNISHINGS (a) Adult care home	06 HOUSEKEEPI					

Division of Health Service Regulation

STATE FORM 9M5721 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED		
HAL051002			B. WING	3. WING 02 /			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AUTUMN	HOME CARE OF JO	HNSTON COUNT	474 JERR SELMA, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
C 166	facilities. This Rule is not me 1- Based on observ maintain the buildin equipment in the ha could affect all pers evacuate the facility Findings include a- A standby ge	e of all obstructions apply to new and exet as evidenced by: rations, the facility has free of hazards by allways near the EXI ons who may need a during an emerger	as failed to vistoring TS. This to locy.	C 166			
C 189	Building Equipment SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an mechanical, and plucare home shall be operating condition. (k) This Rule shall facilities with the exwhich shall not apply This Rule is not mean to be a shall facilities with the exwhich shall not apply This Rule is not mean to be a shall facilities with the exwhich shall not apply This Rule is not mean to be a shall facilities with the exwhich shall not apply This Rule is not mean to be a shall facilities with the exwhich shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall be a shall facilities with the exwhich shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall facilities with the shall not apply This Rule is not mean to be a shall not apply This Rule is not mean to be a shall not apply This Rule is not mean to be a shall not apply This Rule is not mean to be a shall not apply This Rule is not mean to be a shall not apply This Rule is not mean to be a shall not apply This Rule is not mean to be a shall not apply This Rule is not mean to be a shall not apply This Rule is not mean to be a shall not apply Thi	PHYSICAL PLANT 11 OTHER Id all fire safety, electronic discrete and entered in a safety apply to new and exception of Paragraphy to existing facilities at as evidenced by actions, the facility hading is safe by not not building componentifiect all residents, pring the possible specifical in the possible specifical i	etrical, n an adult e and disting h (e) s. as failed to naintaining nts. This ersonnel, read of	C 189			

Division of Health Service Regulation STATE FORM

6899 9M5721 If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01			(X3) DATE SURVEY COMPLETED		
	HAL051002		B. WING			02/12/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
AUTUMN HOME CARE OF JOHNSTON COUNT 474 JERRY SELMA, NC							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
C 189	Continued From page 3			C 189			
		e: rge crack in the ceili it the attic access.	ing along				
	2- Based on observations, the facility has failed to maintain the fire safety systems safe and operating. This deficiency may affect residents during a power outage Findings include: a- The emergency light across from the Resident Bath does not operate on battery power.						
C 195	95 Hot Water System		C 195				
	provide an adequat kitchen, bathrooms closets and soil utili temperature at all fi be maintained at a (38 degrees C) and F (46.7 degrees C). (k) This Rule shall facilities with the ex	system shall be of sure supply of hot water, laundry, housekee ity room. The hot with tures used by residentiminimum of 100 deer shall not exceed 11	er to the ping atter dents shall grees F 6 degrees kisting the feet of the fee				
	This Rule is not me 1- Based on observ	et as evidenced by: vations, the facility h	as failed to				

6899

Division of Health Service Regulation STATE FORM

9M5721 If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		HAL051002	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER N HOME CARE OF JO	HNSTON COUNT 474 J	TADDRESS, CITY, ERRY ROAD IA, NC 27576	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 195	ensure that the wat maintained betwee Fahrenheit. This aff providing hot water Findings includ a- The water te	er temperature is being n 100 and 116 degrees fects all residents by not	C 195			

6899

Division of Health Service Regulation STATE FORM